Texas Department of Health

PRECEPTOR STATEMENT FOR LICENSE APPLICATION

PREPARED FOR CONSIDERATION TO RAM LICENSE NUMBER: _____

Statement must be completed and signed by the physician's preceptor. If more than one preceptor is necessary to document experience, obtain a separate statement from each. Equivalent forms, including those from other Regulatory Agencies, will be accepted. Print or type unless otherwise stated.

1. Applicant's full name and address.	Dates of training

Clinical Training and Experience of the Proposed Physician User

	Column A Radionuclide	Column B Conditions Diagnosed or Evaluated	Column C Number of Cases Involving Personal Participation*	Column D Comments
§289.256(x)and(y)	I-125 or I-131 or Co-57 or Co-58	Diagnosis of Thyroid Function		
		Blood Volume or Blood Plasma Volume		
		Liver Function		
		Kidney Function Studies		
		In vitro Studies		
		Schilling Test		
		(other)		
	I-125	Detection of Thrombus		
	In-111	Labelled WBC for Infection Imaging		
		Cisternogram/Shunt Patency Imaging		
	Ga-67	Abscess or Tumor Imaging		
	Xe-133	Pulmonary Ventilation/Blood Flood Imaging		
	I-123	Thyroid Imaging/Uptake		
	Tl-201	Cardiac Perfusion Imaging		
	Tc-99m	Cardiac Perfusion, E.F., Gated Wall Motion		
		Blood Pool Imaging		
		Bone Imaging		
		Sentinel Node Imaging		
		Breast (Mammoscintography) Imaging		
		Cystography/Ureteral Reflux Imaging		
		Diverticulum Imaging		
		Gastric Emptying and Reflux Imaging		
		GI Bleed Imaging		
		Hepatobiliary Imaging		
		Liver/Spleen and Bone Marrow Imaging		
		Lung Perfusion Imaging		
		Myocardial Infarction Imaging		
		Renal Perfusion/GFR Imaging		
		Thyroid and Salivary Imaging		
		Venography/Thrombus Imaging		
		(other)		
	F-18(etc.)	P.E.T. Imaging		
	RADIOPHARMACEUTICAL PREPARATION			
256(z)	Mo/Tc	Generator Elution and Testing		
	Tc-99m	Reagent Kit Preparation and Testing		
		(other)		

Proposed Physician User:

PRECEPTOR FROM (continued)

Column A Radionuclide	Column B Condition Treated	Column C Number of Cases Involving Personal	Column D Comments
I-131 (NaI)	Hyperthyroidism/Graves/Multinodular Goiters		
	Thyroid Cancer/Metastasis		
I-131 (MoAb)	Non-Hodgkin's Lymphoma		
Y-90 (MoAb)	Non-Hodgkin's Lymphoma		
P-32(soluble)	Polycythemia etc.		
P-32(colloidal)	Intracavitary malignant effusions etc.		
Sr-89	Palliative Bone Pain from Bone Metastasis		
Sm-153	Palliative Bone Pain from Bone Metastasis		
	(other e.g., Investigational Drugs)		
Sr-90	Superficial eye conditions		
I-125	Eye plaques		
I-125	Interstitial Cancer		
Pd-103	Interstitial Cancer		
Au-198	Interstitial Cancer		
Cs-137	Intercavitary Cancer		
Ir-192	Interstitial Cancer		
Co-60	External Beam Therapy		
Ir-192	High Dose Rate After-loader Therapy		System
Sr-90, P-32, Ir-192	Intravascular Brachytherapy		System
	(other)		

*KEY TO COLUMN "C"

1) Supervise examination of patients to determine the suitability for radionuclide diagnosis and/or treatment and recommendation for prescribed dosage.
2) Collaboration in dose calibration and actual administration of dose to the patient including calculation of the radiation dose, related measurements and plotting of data.
3) Adequate period of training to enable physician to manage radioactive patients and follow patients through diagnosis and/or course of treatment.

SEE 25 TAC §289.256(ff)

A. TOTAL HOURS OF TRAINING COMBINED CLINICAL AND WORK EXPERIENCE: _____ HOURS WHERE OBTAINED _____

- (DIAGNOSTIC PHYSICIAN USER TRAINING MUST HAVE INCLUDED THE FOLLOWING)
- ORDERING, RECEIVING, UNPACKAGING, SURVEYING
- CALIBRATING DOSE CALIBRATORS AND DIAGNOSTIC INSTRUMENTS
- CALIBRATING AND PREPARING PATIENT DOSES
- USING ADMINISTRATIVE CONTROLS TO PREVENT MISADMINISTRATIONS
- CONTAIN SPILLS AND PERFORM DECONTAMINATION
- ELUTE Mo/Tc GENERATORS, TEST ELUATE AND PREPARE KITS
- REVIEW PATIENT HISTORY; SELECT MEASURE AND ADMINISTER DOSAGES; COLLABORATIVE REPORTING; FOLLOW-UP
- PHYSICS AND INSTRUMENTATION; PROTECTION; MATHEMATICS; PHARMACEUTICAL CHEMISTRY; RADIATION BIOLOGY

TOTAL HOURS OF DIDACTIC (CLASSROOM AND LABORATORY TRAINING: _____ HOURS WHERE ATTENDED _____

[OR]

B. COMPLETE FULL-SCOPE NUCLEAR MEDICINE TRAINING WITHIN A RESIDENCY ACCREDITED BY EITHER ACGMIE OR COPT-AOA.
PROGRAM DIRECTOR _____. TOTAL NO. OF MONTHS COMPLETED _____

[OR]

C. ACCEPTED BOARD SPECIALTY: _____. DATE ISSUED _____

I CERTIFY THAT THE ABOVE NAMED PHYSICIAN SUCCESSFULLY COMPLETED THE SPECIFIED TRAINING WITHIN THE INSTITUTIONAL APPROVED TRAINING PROGRAM

_____, at _____ _____

NAME OF PHYSICIAN (PRECEPTOR) INSTITUTION SIGNATURE

_____ _____ _____

INSTITUTIONAL RAM LICENSE No. ADDRESS TELEPHONE No.

NRC State ☐
Agreement State ☐
Expiration Date _____

_____ _____

CITY/STATE/ZIP DATE